STATE OF WASHINGTON
Department of
Licensing

SUBSTANCE ASSESSMENT / TREATMENT REPORT

This report to be filed with: Department of Licensing, PO Box 9030, Olympia, WA 98507 • Phone: 360-902-3900
Fax: 360-664-2298

PLEASE PRINT **Reports will be returned if complete name, date of birth, and/or driver license number are not provided.**

CLIENT NAME *(Last, First, Middle)*		WASHINGTON DRIVER LICENSE NUMBER
RESIDENCE ADDRESS ☐ PLEASE CHECK IF NEW ADDRESS		DATE OF BIRTH
CITY	STATE	ZIP CODE
MAILING ADDRESS		
CITY	STATE	ZIP CODE
AGENCY NAME		AGENCY PHONE NUMBER
AGENCY STREET ADDRESS		AGENCY GREENBOOK NUMBER
CITY	STATE	ZIP CODE

Assessment

I completed an assessment of the above named person on _____.
ASSESSMENT DATE

My findings are:*

☐ **Insufficient evidence of substance abuse/dependence.** Persons with a low or minimal probability of reoffending, for whom intervention in the form of Alcohol/Drug Information School is required to address their problem with substance use and driving.

☐ **Substance abuse.** Persons with a greater probability of reoffending without intervention, but for whom substance dependence is not the apparent primary problem at this time. Extensive education/prevention, as part of a treatment program, is required, but intensive treatment for substance dependency is not indicated.

☐ **Substance dependence.** Persons with a greater probability of reoffending if not treated, for whom substance dependence at any stage of the disease is the primary problem at this time. This category would include persons that come to the assessment at any stage of the disease recovery process (including all persons indicating recovery through non-treatment means).

** These criteria are intended to serve as guidelines for determining the appropriate reporting level.*
It is the responsibility of the assessment professional to identify and document the symptoms which support their decision in the patient record.

X _____ _____
SIGNATURE OF CERTIFIED CHEMICAL DEPENDENCY PROFESSIONAL / ASSESSMENT OFFICER — DATE SIGNED

Information School

☐ Client completed information school on _____.
COMPLETION DATE

X _____ _____
SIGNATURE OF CERTIFIED INFORMATION SCHOOL INSTRUCTOR — DATE SIGNED

Treatment Reports--Submit within 5 days

CHECK ALL APPROPRIATE BOXES

☐ **Progress.** Treatment began on _____. Patient completed first 60 days with satisfactory progress.
DATE PROGRAM BEGAN

☐ **Noncompliance report.** Patient is noncompliant (includes any violation of the treatment plan that reflects the patient's unwillingness or failure to participate).

☐ **Compliance report.** Patient is again complying with treatment program.

☐ **Transfer report.** Patient transferred: ☐ In ☐ Out on _____.
TRANSFER DATE

☐ **Discharge report.** Patient completed treatment and aftercare program: ☐ Yes, on _____.
COMPLETION DATE
☐ No, _____.
EXPLAIN

X _____ _____
SIGNATURE OF CERTIFIED CHEMICAL DEPENDENCY PROFESSIONAL — DATE SIGNED

The Department of Licensing has a policy of providing equal access to its services. If you need special accommodation, call (360) 902-3900 or TTY (360) 664-0116.